DEPARTMENT OF THE NAVY
NAVAL AIR WARFARE CENTER AIRCRAFT DIVISION
22347 CEDAR POINT ROAD, UNIT 6
PATUXENT RIVER, MARYLAND 20670-1161

NAVAIRWARCENACDIVINST 12810.1 CH-2
732000A
JUN 30 2000

NAVAIRWARCENACDIV INSTRUCTION 12810.1 CHANGE TRANSMITTAL 2

From: Commander, Naval Air Warfare Center Aircraft Division

Subj: INJURY COMPENSATION PROGRAM

Encl: (1) Dispensary Permit, OPNAV 5100/9 (Rev. 10/92)

1. Purpose. To issue Change Transmittal 2 to the subject instruction.

2. Action. Addressees shall make the following changes to the instruction:

a. Page 1, paragraph 2, change "Benefits and Services (Code 731400)" to "Work Force Relations and Development Division (Code 732000)."

b. Page 2, paragraph 6a(3), change "Oct 1988" to "Apr 99."

c. Enclosure (2):

(1) Paragraph 1b, add "/Compensation" before (COP).

(2) Paragraph 1c, delete "(Code 7.3.1.4)."

(3) Paragraph 2a(1), change "Code 7.3.1.4" to "local ICP Administrator."

(4) Paragraph 2b, delete "(Code 7314)."

d. Enclosure (4):

(1) Paragraph 1a, change "90" to "45."

(2) Paragraph 3a(7), change "90 days or more following injury" to "more than 45 days following injury."

(3) Paragraph 3b(1), change "35" to "36."

(4) Paragraph 3b(2), change "7314" to "local ICP Administrator."

e. Remove enclosure (5) and replace it with the attached enclosure (1) to this change transmittal.

f. Enclosure (8), paragraph 3b, change "Code 7314" to "Local ICP Administrator."

g. Enclosure (9):

(1) Page 1, first column, second row, change "CA-1" to "CA-2."

(2) Delete forms CA-8 and CA-20a.

J. W. DYER

Distribution:
List I

Dispensary Permit

PRIVACY ACT STATEMENT BELOW

CASE NUMBER

SUPERVISOR'S REPORT	TO DISPENSARY (Location)	DATE OF REPORT	
EMPLOYEE'S NAME	TIME & DATE OF INJURY	TIME LEFT JOB	TIME RETURNED
SOCIAL SECURITY NO. / GRADE, RATE, JOB TITLE		OCCUPATIONAL ☐ YES ☐ NO ☐ QUESTIONABLE	
REASON FOR REFERRAL ☐ INJURY ☐ ILLNESS ☐ EMPLOYEE'S REQUEST ☐ OTHER (Specify)			
REMARKS			
SUPERVISOR'S SIGNATURE	SHOP/OFFICE	TELEPHONE NUMBER	
MEDICAL OFFICER'S REPORT	TIME REPORTED	TIME RELEASED	
OCCUPATIONAL ☐ YES ☐ NO ☐ QUESTIONABLE	DEGREE OF INJURY ☐ FIRST AID ☐ MEDICAL TREATMENT ☐ OTHER (Explain)		
DISPOSITION OF EMPLOYEE ☐ RETURN TO PERM. JOB_____ ☐ TEMP. TRANSFER TO ANOTHER JOB ☐ TERMINATION OF EMPLOYMENT ☐ RESTRICT ACTIVITY UNTIL _____ ☐ PERM. TRANSFER TO ANOTHER JOB ☐ SENT HOME BY DISPENSARY ☐ REFERRED TO PRIVATE PHYSICIAN/HOSPITAL ☐ OTHER (Explain)			
REMARKS/DIAGNOSIS			
MEDICAL OFFICER'S SIGNATURE	INITIAL TREATMENT DETERMINATION ☐ DISCHARGED, TREATMENT COMPLETED ☐ RE-TREATMENT REQUIRED		

OPNAV 5100/9 (Rev. OCT 1992)

PRIVACY ACT STATEMENT

Authority: SECNAVINST 5100.10E and OPNAVINST 5100.23C

Principal Purpose: To ensure prompt investigation of occupational injuries, and to initiate any necessary immediate corrective action.

Routine Use: Routinely used by the activity Occupational Safety and Health Office to perform official duties in the investigation of mishaps which may have caused occupational injury or illness.

Disclosure: Voluntary. Treatment will be provided without regard to employee's willingness to divulge all or part of the requested information.